Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PHYSICIANS AMBULATORY SURGERY CENTER
PO BOX 2101
SAN ANTONIO TX 78297-2101

Respondent Name
HARTFORD UNDERWRITERS INSURANCE

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-10-2101-01

MFDR Date Received
DECEMBER 14, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The cods [sic] of 63030 and 63035 were approved for services at Physicians Ambulatory Surgery Center. Please review the attachments and consider for additional reimbursement." "Provided information is according to Texas Administrative Code, Rule 134.402 for Ambulatory Surgical Center Fee Guidelines and Rule 133.250(f) reconsideration of medical bills, as well as Rule 134.204 Medical Fee Guidelines for Worker's Compensation Specific services and Rule 134.201 (B) Medical Fee Guidelines for Medical Treatment and Services provided under the Texas Workers Compensation Act."

Amount in Dispute: $25,556.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ASC fee schedule does not contain billed codes. Pd at UCR rate. Please see attached."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2009	ASC Services for CPT Code 63030 and 63035	$25,556.55	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, set out the reimbursement guidelines.
3. Division rule at 28 TAC §134.1(f) effective August 31, 2008, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

   - W1-WC state fee sched adjust. Reimbursement according to the Texas Medical Fee Guidelines.

Findings

1. This dispute related to ambulatory surgical care services rendered on August 14, 2009, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.402.
2. 28 Texas Administrative Code §134.402(b)(6) defines "'Medicare payment policy' means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   The requestor billed the following CPT codes:

   "63030-Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar."

   "63035-Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)."
3. 28 Texas Administrative Code §134.402(d) states "For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs."
4. 28 Texas Administrative Code §134.402(e) states "Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any reimbursement for implantables.

   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   The Division finds that reimbursement in this dispute is not applicable to a contractual fee schedule; therefore, reimbursement for this dispute is applicable to 28 Texas Administrative Code §134.402(e)(2) or (3).
5. 28 Texas Administrative Code §134.402 (f) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor."

   A review of the Addendum AA, ASC Covered Surgical Procedures for CY 2009 finds that CPT codes 63030 and 63035 are not included. Therefore, these services do not have a MAR as outlined in 28 Texas Administrative Code §134.402(f); therefore, reimbursement shall be determined in accordance with 28 Texas Administrative Code §134.1 and §413.011(d).
6. 28 Texas Administrative Code §134.1(f) states "Fair and reasonable reimbursement shall:
   (1) be consistent with the criteria of Labor Code §413.011;
   (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
7. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
8. 28 Texas Administrative Code §133.307(c)(2)(G), requires the requestor to provide "documentation that

discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

- The requestor seeks full reimbursement of billed charges based upon "The cods [sic] of 63030 and 63035 were approved for services at Physicians Ambulatory Surgery Center. Please review the attachments and consider for additional reimbursement." "Provided information is according to Texas Administrative Code, Rule 134.402 for Ambulatory Surgical Center Fee Guidelines and Rule 133.250(f) reconsideration of medical bills, as well as Rule 134.204 Medical Fee Guidelines for Worker's Compensation Specific services and Rule 134.201 (B) Medical Fee Guidelines for Medical Treatment and Services provided under the Texas Workers Compensation Act."
- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor did not submit documentation to support that additional reimbursement of $25,556.55 is a fair and reasonable reimbursement for the services in this dispute.
- The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/30/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.